Meadows Mental Health Policy Institute

Request for Information: Interim Charge #1 (HB 3285) – October 2020

House Committee on Public Health

Beyond the physical health consequences of the COVID-19 pandemic, the shutdown, economic recession, and social isolation are leading to **additional behavioral health needs** for Texans.

In April 2020, the Meadows Mental Health Policy Institute (MMHPI) issued the first in a series of reports analyzing the behavioral health impacts of the COVID-19 pandemic. Our initial report projected the impact of a COVID-induced economic recession on increases in rates of suicide, illicit-drug-related deaths, and substance use disorder (SUD). Our second report updated the original report with state-level projections. Other studies have estimated comparable levels of morbidity and mortality.[1]

These reports forecasted how COVID-19-driven unemployment could cause potential increases in mortality from suicide and drug overdose as well as increases in SUD. This modeling assumed that treatment availability would remain stable at pre-pandemic levels, an assumption that is now proving to be excessively optimistic.[2] Since those reports, the Centers for Disease Control and Prevention has released updated drug overdose death statistics, including data showing that drug overdose deaths have been increasing year-over-year[3] and that this trend may be increasing due to COVID-19.[4] Our original projections suggested that for every five-percentage-point increase in the unemployment rate compared to pre-pandemic levels, an additional 4,000 Americans, including 300 Texans, could be lost to suicide; our updated projections add 5,500[5] American drug overdose deaths to pre-COVID-19 levels, including 425 Texans.

In response to the committee's request for information on programs and initiatives to prevent and respond to opioid addiction, misuse, abuse, and overdose and identify and treat co-

[1] Patterson, S., Westfall, J. M., & Miller, B. F. (2020, May 8). *Projected Deaths of Despair During the Coronavirus Recession.* https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf

[2] National Council for Behavioral Health. (2020, April 15). *COVID-19 economic impact on behavioral health organizations.* https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56

[3] Ahmad, F. B., Rossen, L. M., & Sutton, P. (2020, July 15). *Provisional drug overdose death counts*. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[4] Alter, A. & Yeager, C. (2020, May 13). *The consequences of COVID-19 on the overdose epidemic: Overdoses are increasing*. http://odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf

[5] Our earlier models suggested that 4,800 Americans would die from drug overdose deaths. These models have been updated to use more current data from the Centers for Disease Control and Prevention and now reflect an anticipated 5,500 drug overdose deaths per 5% increase in the national unemployment rate. State-level estimates were also updated similarly.

occurring SUD and mental illness, MMHPI provides the following recommendation for the Texas Medicaid program:

Collaborative Care

The **collaborative care model (CoCM)** is a proven tool to detect and prevent suicide and overdose in primary care before they become crises. Unfortunately, less than one in twenty Americans can currently access it.

CoCM uses a team-based approach to care[6] that routinely measures both clinical outcomes and patient goals over time to increase the effectiveness of mental health and SUD treatment in primary care settings.[7,8] CoCM is an established evidence-based practice that has been shown to reduce depression, bipolar and anxiety disorders, SUD, suicidal ideation, and suicide completion.[9,10] CoCM is also the only evidence-based medical procedure currently reimbursable in primary care — it has been covered by Medicare since 2017[11] and by nearly all commercial payers since 2019[12] — and it is the only model with strong evidence of cost savings.[13,14,15] The potential cost-savings of wide-spread implementation are considerable; a 2013 study found

[6] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes*. Health Home Information Resource Center. http://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

[7] Nafziger, M., & Miller, M. (2013). *Collaborative primary care: Preliminary findings for depression and anxiety* (Doc. No.13-10-3401). Washington State Institute for Public Policy. http://www.wsipp.wa.gov/ReportFile/1546/Wsipp_Collaborative-Primary-Care-Preliminary-Findings-for-Depression-and-Anxiety_Preliminary-Report.pdf

[8] Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine: five-year experience. *Archives of Internal Medicine*, *171*(5), 425-431. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/226781

[9] Bower, P., Gilbody, S., Richards, D., Fletcher, J., & Sutton, A. (2006). Collaborative care for depression in primary care: Making sense of a complex intervention: Systematic review and meta-regression. *The British Journal of Psychiatry, 189*(6), 484–493. https://doi.org/10.1192/bjp.bp.106.023655

[10] Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr, Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., & Langston, C. (2002, December 11). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA, 288*(22), 2836–2845. https://doi.org/10.1001/jama.288.22.2836

[11] Center for Medicare and Medicaid Services. (2019, May). *Behavioral health integration services.* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[12] Alter, C., Carlo, A., Harbin, H., & Schoenbaum, M. (2019, July 3). Wider implementation of collaborative care is inevitable. *Psychiatric News, 54*(13), 6-7. https://doi.org/10.1176/appi.pn.2019.6b7

[13] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.

[14] Press, M. J., Howe, R., Schoenbaum, M., Cavanaugh, S., Marshall, A., Baldwin, L., & Conway, P. H. (2017, February 2). Previously cited.

[15] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018, January). *Potential economic impact of integrated medical-behavioral healthcare. Updated projections for 2017*. https://milliman-cdn.azureedge.net/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx

savings in Medicare and Medicaid settings of up to 6 to 1 in total medical costs and estimated $15 billion in Medicaid savings if only 20 percent of beneficiaries with depression receive it.[16] Despite its effectiveness and savings, implementation has been slow.[17]

In August 2020, MMHPI issued a report modeling the extent to which universal access to evidence-based integrated primary care to treat major depression through CoCM could offset a portion of the predicted increases in suicide from the pandemic. In Texas, our models suggest universal access to collaborative care to treat major depression could reduce the number of suicide deaths[18] by between 725 and 1,100 deaths per year.

Recommendation: Add Current Procedural Terminology (CPT) codes 99492-99494 for CoCM to Texas Medicaid, for both children and adults, to increase access to behavioral health services integrated in primary care. Fifteen other states currently reimburse for CoCM in their Medicaid programs.[19]

Medication-Assisted Treatment

Medication-Assisted Treatment (MAT) includes the provision of medications such as methadone, naltrexone, and buprenorphine as well as counseling to reduce the symptoms of withdrawal and to support people in recovery from opioid addiction. The scientific literature is clear that MAT reduces relapse and drug overdose death.[20] However, many barriers to universal MAT access remain, especially for rural areas.[21] Rural primary care providers are among the least likely to be trained and authorized to prescribe MAT, leaving 30 million

[16] Unützer, J., Schoenbaum, M., & Druss, B. (2013, May). Previously cited.
[17] Katon, W., Unützer, J., Wells, K., & Jones, L. (2010). Collaborative depression care: History, evolution, and ways to enhance dissemination and sustainability. *General Hospital Psychiatry*, *32*(5), 456–464. https://doi.org/10.1016/j.genhosppsych.2010.04.001
[18] We calculated a range of suicide deaths that could be prevented if CoCM were expanded. The low-end estimate was calculated by assuming that half of deaths from suicide were caused by depression (based on WSIPP, 2019; http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf), and the high-end estimate was generated under the assumption that as many as 80% of deaths from suicide are caused by depression, based on Beautrais, A. L., Joyce, P. R., Mulder, R. T., Fergusson, D. M., Deavoll, B. J., & Nightingale, S.K. (1996). Prevalence and comorbidity of mental disorders in persons making serious suicide attempts: A case-control study. *American Journal of Psychiatry, 153*(8), 1009–1014. https://doi.org/10.1176/ajp.153.8.1009
[19] Raney, L. (2020, September). *Cracking the Codes: State Medicaid Approaches to Reimbursing Psychiatric Collaborative Care.* California Health Care Foundation. https://www.chcf.org/wp-content/uploads/2020/09/CrackingCodesMedicaidReimbursingPsychiatricCollaborativeCare.pdf
[20] Ma, J., et al. (2019). Previously cited.
[21] Andrilla, C. H. A., Moore, T. E., Patterson, D. G., & Larson, E. H. (2019). Geographic distribution of providers with a DEA waiver to prescribe buprenorphine for the treatment of opioid use disorder: A 5-year update. *The Journal of Rural Health*, *35*(1), 108–112. https://doi.org/10.1111/jrh.12307

Americans, including millions of Texans, living in counties without access to MAT.[22,23] In Texas, the under-treatment of opioid use disorder has been called a public health crisis, as only 10% of counties have a provider authorized to prescribe MAT.[24] Training and authorizing more primary care providers to prescribe MAT would increase access to this needed treatment.[25]

In August 2020, MMHPI issued a report estimating how many drug overdose deaths would be prevented if all people with opioid use disorder had access to MAT compared to baseline levels of access to MAT.[26] The relative risk of overdose, which includes adjustments based on age and other factors, is 8.1 times higher for people with opioid use disorder who did not receive MAT compared to those with access to MAT. When the overdose mortality rate for untreated individuals is applied to the estimated number of Americans and Texans with opioid use disorder,[27] MMHPI projects that 24,000 of the nearly 50,000 annual deaths from overdose across the United States each year could be prevented, including 1,600 of the more than 3,000 overdose deaths that occur annually in Texas. Because overdose rates increase if MAT is not continued, though not to the rates seen in untreated populations, the mortality rate could be even lower to the extent that more people remain in treatment over time.

Recommendation: Incentivize Medicaid managed care organizations to expand access to MAT in primary care and establish contract performance measures to track the number of people enrolled in Texas Medicaid with opioid use disorder who are receiving MAT.

Tele-behavioral Services

Following President Trump's March 13, 2020 declaration of a national emergency due to the COVID-19 pandemic, governors across the country restricted in-person commerce at non-essential businesses. This led to restrictions on elective medical procedures and the virtualization of medical services for which in-person care was not essential. The result has

[22] Rosenblatt, R. A., Andrilla, C. H. A., Catlin, M., & Larson, E. H. (2015). Previously cited.
[23] Legislative Budget Board Staff. (2019, April). Overview of opioid crisis in Texas. http://www.lbb.state.tx.us/Documents/Publications/Staff_Report/2019/4616_Opioid_Crisis.pdf
[24] Hobby School of Public Affairs, University of Houston. (2018). *The opioid epidemic in Texas: Current policies and possible policy reforms.* https://uh.edu/hobby/_docs/research/the-opioid-epidemic-in-texas.pdf
[25] Korthuis, P. T., McCarty, D., Weimer, M., Bougatsos, C., Blazina, I., Zakher, B., Grusing, S., Devine, B., & Chou, R. (2017). Primary care-based models for the treatment of opioid use disorder: A scoping review. *Annals of Internal Medicine*, *166*(4), 268–278. https://doi.org/10.7326/m16-2149
[26] Case management and behavioral therapies are commonly used in conjunction with MAT and may reduce mortality — see Davoli, M., et al. (2007). Previously cited. The vast majority of studies in the Ma et al. (2019) meta-analysis did not reference these additional forms of therapy in conjunction with MAT.
[27] Substance Abuse and Mental Health Services Administration. (2019). *Behavioral health barometer: United States, volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*. HHS Publication No. SMA–19–Baro-17-US. Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/product/Behavioral-Health-Barometer-Volume-5/sma19-Baro-17-US

been an unprecedented shift to the delivery of care through telemedicine, telehealth, and telephone (audio only), with flexibilities offered at both the state and federal level.

On March 20, 2020, Governor Abbott and the Health and Human Services Commission (HHSC) issued a series of waivers to provide flexibility in the Texas Medicaid program. HHSC authorized certain behavioral health services to be reimbursed in Medicaid when delivered by telemedicine, telehealth, or telephone (audio only). HHSC renewed the authorization for these procedure codes on a monthly basis until July 31, 2020, when the authorization was extended through October 23, 2020.

A large evidence base supports telepsychiatry as an effective delivery method for mental health services.[28] Moreover, accessing tele-behavioral services has been a vital strategy to mitigate the spread of COVID-19. The resulting shift to technology has alleviated mental health professional shortages by making services more accessible for people in need, including those in rural and underserved areas. Audio-only services ensure that behavioral health providers can provide treatment to people who have no access to broadband or other technology. Any rollback of these policies will compromise the ability of Medicaid recipients to access much-needed mental health and SUD treatment and will lead to higher costs through delays in treatment and worsening conditions.

Recommendation: Amend statute to ensure continued, and permanent, Medicaid reimbursement for the following services and related procedure codes authorized to be delivered by telemedicine, telehealth, and telephone (audio only).

Conclusion

Thank you for the opportunity to provide data-based information and recommended solutions to the House Committee on Public Health. MMHPI stands ready to serve as a resource as you gather information and consider actionable solutions for your interim charges.

[28] Hubley, S., Lynch, S. B., Schneck, C., Thomas, M., & Shore, J. (2016, June). Review of key telepsychiatry outcomes. *World Journal of Psychiatry*, 6(2), 269–282. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4919267/